# Washington State 1115 Waiver Public Comments

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The Washington State 1115 Waiver application and concept paper is a well-crafted system transformation initiative that will significantly change the way care is delivered to low-income patients. Medicaid patients are entitled to health care that is consistent with relation to accessibility, coordination, quality and complementation by robust community support services. This multi-faceted approach to patient care and wellness lays the foundation for CMS-driven payment reform, such as value-based purchasing.

Our team has unparalleled experience working from design phase into deep implementation with providers and renewal planning/analysis with other delivery system reform incentive payment (DSRIP) programs in California, Texas and New York. We would like to share the following comments based on the successes we've seen. In addition, there are some crucial lessons learned from what other states have experienced in implementing such significant system transformation. Our comments are related specifically to Initiative 1: Transformation through Accountable Communities of Health (ACHs).

**Empower your ACH leads in the waiver administration:**
*Referencing Page 10 of the Concept Paper: "ACHs will serve as the coordinating entities to develop applications for DSRIP financing."*

ACHs are designed to align priorities, actions and investments to facilitate and support their memberships to develop and sustain more accountable and integrated care delivery. The role of an ACH/DSRIP coordinating entity is a heavy lift – the manpower required to properly administer regional transformation change can be significant. Washington should consider ensuring ACHs are awarded initial planning and ongoing administrative funds to hire staff who can perform the multitude of DSRIP coordinating activities and to develop core infrastructure to set a foundation for success. This includes but is not limited to:

1. ACH education of provider staff
2. Stakeholder and public education on 1115 Waiver
3. Funds flow development
4. Contracting and legal
5. Project implementation and management
6. Lead steering, clinical, IT and other workgroups
7. Assess and build IT infrastructure needs for the region to implement 1115 projects. Develop timely, accurate, and actionable reports that can be analyzed for rapid process improvement
8. Lead the region in developing clinical priorities and selecting appropriate activities
9. Fund new services designed to reduce unnecessary intensive services consistent with Triple Aim

**Projects should be designed for multiple provider types with clear expectations:**
*Referencing Page 7 of the Concept Paper: "The state is proposing four investment domains that advance Washington's strategies for sustainable Medicaid transformation."*

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Our experience is that the regional approach for implementing transformation is a crucial piece of DSRIP. By requiring activities across many providers, the necessary collaboration and coordination is encouraged to create an integrated delivery system. However, this approach also comes with its own challenges in developing measurable milestones for DSRIP payments.

1115 Waiver project design should consider the variety of providers who will be participating, with an understanding of the role that each provider will play. For example, a care transitions project should reward primary care providers for achieving different milestones than a nursing home. The primary care provider, for example, would receive funds for properly implementing a patient centered medical home that provides, coordinates and integrates a spectrum of services designed to meet the goals and objectives of the 1115 Waiver.

One of the largest challenges in New York DSRIP has been intentionally designing, agreeing upon and ensuring the correct financial incentives for the role of every single provider in DSRIP, from the hospital to the single primary care provider to the patient navigator and the LTSS delivery system. Many or all of these providers will likely be eager to participate in DSRIP but may be unclear on their expectations if there is limited guidance on how specifically they will be paid based on their role, activities and outcomes. We recommend setting up at least clear payment/reimbursement methodology guidelines upfront to advance and sustain the 1115 Waiver objectives.

**DSRIP funds should advance, support and align with outcomes/care improvement metrics:**
*Referencing Page 10 of the Concept Paper: "Allocation of DSRIP funds over the five-year demonstration period will be contingent on performance tied to the milestones and performance measures."*

It is no secret that CMS has begun encouraging providers toward value-based purchasing, especially for Medicaid members, New York State has partnered with CMS to set very aggressive and time-bound goals for this activity – setting a new bar for other states. Providers must prepare for this shift, which may come more rapidly than they expected and have planned for. Accordingly, funds should flow to the regions based on outcomes and care improvement metrics in the latter years of the waiver.

In the initial years, DSRIP payments are usually given for achieving process milestones. Providers are rewarded for opening new clinics, implementing care transitions programs, community outreach programs, expanding specialty care, hiring providers, etc. Linking funds to infrastructure development and capacity building in the beginning of the waiver allows providers to build the necessary structures to begin improving outcomes.

The Texas DSRIP waiver has a pretty even split between process milestones and outcomes milestones. The New York waiver places more emphasis on outcomes, as the state is closer to value-based purchasing and payment reform. Washington should strongly consider the current landscape and how prepared its providers are for value-based purchasing. We recommend the 1115 Waiver program design funds flow to push providers and align them with achieving outcomes.

**Health plans should be at the table but not controlling the payments to the ACHs:**
Health plans need to be involved early on in ACH's, but in a defined role. We recommend that the ACH has a direct contract with the state for an assigned number of enrollees with providers and plans having representation on the ACH. Health plans contribute significant resources and experience due to their current roles. However, our experience is that aggregated claims data can be a rich resource for system transformation and feedback if it is timely, accurate and actionable. We recommend either the state or a single plan process claims for the ACH.

**Data presents opportunities but can be a significant blocker**

Much of the DSRIP design and payment in Texas and New York hinges on the availability of data.

In Texas, limited access to Medicaid data and a severe lack of HIT infrastructure in the state has led to stunted reported capabilities by providers; data availability commonly dictated what clinical outcomes providers chose, even though they may not be the most appropriate metrics. Providers do not have access to statewide claims data and must rely on their own internal data systems to report on many population measures. This limited data reduces the ability of the state to measure the impact of DSRIP because reported data is not standardized across providers.

In New York, much of the DSRIP project design and funds flow is dependent on data availability. Medicaid members are attributed to the performing provider systems (for waiver purposes only at this time). The number of lives attributed to a PPS impacts the scale of the milestone goals, and the number of lives also affects the valuation of the projects. However, much of the data crucial to planning the projects comes from state claims data, which is on a year-plus delay. In addition, much of the data analysis is being done by the state, which is a large administrative burden and causes further delays in information to the providers. This will cause significant obstacles in timely reporting of clinical outcomes for payment.

Washington state must consider 1) what data is available to providers as part of the DSRIP planning and measurement phases; 2) what data will need to be made available to providers; 3) what level of analytics and support will need to be given to providers; and 4) how claims data delays may impact DSRIP.

**Anti-trust issues must be dealt with early**

The purpose of creating a regional transformation plan under the 1115 Waiver is to encourage collaboration, care coordination and continuity for patients. In New York, several managed care organizations have raised concerns that DSRIP may lead to anti-trust activities, particularly with relation to Commercial lines of business. New York State has taken some regulatory steps toward addressing this issue, but much remains to be seen. Clarifying antitrust risks up front and developing clear guidance to the ACHs, providers and health plans in advance, to the extent possible, will reduce distractions during the design, implementation and transition process.

**Providers value flexibility but with clarity**

On a more general note, we have seen DSRIP roll out in several states with in such a way that it has generated varying degrees of frustration among providers. Often, the difference between exasperating your providers and not is the level of 1) direct communication from the state, 2) flexibility and adaptability, 3) adherence to deadlines for provision of information/data, 4) clarity in design and 5) clarity with relation to how providers can provide feedback to have a timely impact on design both ahead of time and as the rollout is underway and learning occurs.

Flexibility and adaptability are key to allow providers across the state, who will have different patient populations, health needs, access to care, transportation options and geographies, the ability to customize the DSRIP program for their region. Flexibility and adaptability include:

1. DSRIP menu options that providers can provide early input on based on their local geographic and related needs prior to finalization – and a process for updating based on learning in the early years
2. Ability to decide which providers are included in the DSRIP program and how at the ACH level and for sub-contracting by providers

3. Clear and flexible funds flow methodology that allows for significant customization at the ACH and provider level in order to design the necessary incentives to match their specific population needs, provider availability, transportation and cultural competency needs, etc

However, open-ended program protocols can also cause frustration when not paired with clarity in certain areas. This includes but is not limited to:

1. Deadlines are set and adhered to, especially on state deliverables to providers
2. Funding amounts to regions are set early
3. Performance incentives and consequence are established
4. Transformation support levels and methodology for accessing them are clear, for instance: training, coaching, workforce development, IT, data
5. Accountability, transparency of information and decisions
6. Evidence-based and best practice protocols that "treat to target"

Our team has extensive experience with the 1115 Waivers, including the California Coverage Initiative and the DSRIP waivers in California, Texas and New York. We would be happy to share our lessons learned and best practices from our hands-on work in planning, implementing and measuring 1115 Waiver transformation programs. We look forward to supporting your transformation.

Thank you for the opportunity to comment,

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